

EMPLOYER'S LIABILITY - CLAIM FORM

IMPORTANT NOTES:

Insurers, their Agents and the Insurance Associations share information with each other to prevent fraudulent claims & for underwriting purposes. In the event of claim, some or all the information you supply to this form and in the claim form together with other information relating to the claim may be provided to other insurers, their agents and insurance associations. All questions must

PART: (A) POLICY HOLDER:

Name of insured

Policy No:

Address

Business/Occupation

Telephone/Mobile /Fax

PART : (B) OCCURRENCE:

Date and time of incident.

Place /location where the incident occurred.

Date reported and to whom?

Describe fully how the accident occurred and what the injured person was doing at the time.

(Please attach extra sheet if below space is not sufficient)

Gross weekly wage of the person

Names and addresses of any witnesses.

DESCRIPTION OF WORK ON WHICH INJURED PERSON WAS ENGAGED.

What injuries have been sustained?

Have you had an injury of the same nature before? YES NO

Has the injured person received proper training or instruction as to how to perform the work? YES NO

Whether the injured person was wearing the safety gear, helmet or protective clothing? YES NO

Was the insured person aware of the dangers whilst exposed to the type of work he was performing?
YES NO

Was the injury suffered due to a fellow employee's fault or negligence? YES NO

Was the injured person exposed to exceptional danger as perceived by the Employers? YES NO

If YES, was the work undertaken under proper supervision and control? YES NO

If machinery was involved, please give details of make, type etc.

State:

What injuries have been sustained?

Whether injured person has ever had an injury to the same part before YES NO

Is the injured person insured elsewhere against accidents? YES NO IF YES, give particulars.

Is the injured person suffering from any disease in addition to the present injuries, or has he any physical defect? YES NO If YES, state the nature of same and to what extent the recovery may be effected thereby.

During what period was the person totally disabled from attending to any art of his occupation/profession?

From To

If recovered, please state date of recovery

****If total disablement continues, please attach completed certificate by the injured person's doctor.****

DECLARATION:

I/We declare that all particulars given are true and complete and claim the sum of Aed. _____ as detailed above as supported by the enclosed documentary evidence.

Signature:

Date